

CHAPTER 9-000 WOMEN'S CANCER PROGRAM: Women who meet the eligibility requirements listed in 469 NAC 9-001 are eligible for Medicaid coverage.

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 allows Medicaid for women who need treatment for breast or cervical cancer. Section 68-1020, Neb. Rev. Stat. authorizes this coverage in Nebraska.

9-001 Eligibility Requirements: In order to receive Medicaid, the woman must:

1. Be screened for breast and cervical cancer by Every Woman Matters;
2. Be found to need treatment for breast and/or cervical cancer, including a pre-cancerous condition or early stage cancer;
3. Be age 64 or younger;
4. Not be otherwise eligible for Medicaid;
5. Not be covered by creditable health insurance (see 469 NAC 9-001.01);
6. Be a Nebraska resident (see 469 NAC 2-003); and
7. Be a U.S. citizen or a qualified alien (see 469 NAC 2-002).

9-001.01 Creditable Health Insurance: For purposes of this program, creditable health insurance includes any health insurance coverage except a plan that:

1. Is limited scope coverage such as those which only cover dental, vision, or long term care;
2. Is coverage for only a specified disease or illness;
3. Does not include treatment for breast or cervical cancer (such as a period of exclusion); or
4. Has exhausted the woman's lifetime limit on all benefits under the plan or coverage, including treatment for breast or cervical cancer.

9-001.02 Eligibility Period: Eligibility begins with the first of the month that the client signs the application for the Women's Cancer Program on the prescribed application which is incorporated into the appendix of these rules.

Eligibility continues as long as the client requires treatment for breast or cervical cancer, as determined by her physician, unless she becomes ineligible for some other reason. Eligibility automatically ends the last day of the month of the client's 65th birthday.

For pre-cancerous cervical conditions, eligibility automatically ends the last day of the month following the month treatment begins unless the physician provides the agency with a monthly statement that continued treatment is required. Continued treatment does not include continued surveillance, testing, or screening.

For breast and cervical cancer, a physician's statement verifying the need for treatment must be provided to the agency every six months for the woman to remain eligible for Medicaid coverage.

9-001.03 Presumptive Eligibility: The client may be determined presumptively eligible by a qualified Medicaid provider. Presumptive eligibility begins on the date that the qualified provider determines that the client appears to meet eligibility criteria.

**Breast and Cervical Cancer
Medicaid Supplement Form**



Name _____

Social Security Number _____

Date _____

I certify that the above named individual has been screened for breast or cervical cancer and found to need treatment for breast or cervical cancer or pre-cancerous lesions.

Every Woman Matter's Representative's Signature _____

Every Woman Matter's Representative (Please Print) _____

MEDICAID INFORMATION

Are you a United States Citizen?

☐ Yes ☐ No If NO, what is your immigration status? (Please attach a copy of your INS papers, if available)

Information on Health Insurance or Indian Health Insurance you already have?

Tell us the name of your insurance company, the policy number and the insured person's name on the policy.

Insurance Company or Employer	Phone Number of Company	Policy Number or Group Plan number	Insured Name on Policy

(We are required to ask the following questions to determine your possible eligibility for other categories of Medicaid.)

Area you Pregnant?

☐ Yes ☐ No (Circle one)

Do you have children under the age of 19 living with you?

☐ Yes ☐ No (Circle one)

Have you been determined disabled by the Social Security Administration or Health and Human Service's State Review Team?

☐ Yes ☐ No (Circle one)

PRESUMPTIVE ELIGIBILITY

I certify that the above woman is eligible for Presumptive Eligibility.

Provider Representative _____

Date of Presumptive Determination _____

Name of Provider _____

Provider Address _____

NOTICE TO PROVIDERS: Please accept this form as proof of temporary Medical coverage for Women with Breast or Cervical Cancer. To check Medicaid Presumptive eligibility use the woman's Social Security Number with a two digit suffix when calling the Nebraska Medicaid eligibility (NMES) line at 1-800-642-6092.

NOTICE TO APPLICANT: Show this form to providers of services as proof of medical coverage. **Notice & Appeal Rights!**
PLEASE SIGN THIS STATEMENT: I certify that the information I have provided above is true to the best of my knowledge and I give permission for the State of Nebraska to make any necessary contacts to check my statements. I have read the list of my rights and responsibilities that is printed below. I know that I could be penalized if I knowingly give false information.

Signature or Mark of Applicant _____

Date _____

Witness if mark _____



printed on recycled paper

Rights and Responsibilities

I understand that this application is an application for one kind of Medicaid and is not a full Medicaid application. I understand that if I am not eligible under this category of Medicaid, I may be eligible for Medicaid benefits on some other basis and have a right to complete a full Medicaid application. If you need assistance with food, utilities, day care or other needs contact your Local Department of Health and Human Service Office.

1. I know that the information I have given is confidential. I agree that medical information about me can be released only if needed to administer this program.
2. I know that any information I have given may be reviewed and verified by the State of Nebraska. I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permissions are needed to get verification or other information.
3. I know that this application will be considered without regard to race, color, sex, age, disability, religion, national origin or political belief.
4. I know that I may ask for a hearing if I am not satisfied with any action taken by the State of Nebraska in connection with the program. I may also ask for a hearing if I feel that I have been discriminated against.
5. I know that the State of Nebraska will request and use information from a computer system called the State Income and Eligibility Verification System (IEVS). This computer system compares information about me with information from other agencies. Other agencies include the Internal Revenue Service, Social Security Administration, Veteran's Administration, Vital Statistics Agency and the Nebraska Department of Labor.
6. I know that Medicaid does not pay medical expenses that a third party, such as a private health insurance company, is suppose to pay. I give my rights to any third party payments to the Department of Health and Human Services. These payments may include payments from hospital and health insurance policies. I know that if I refuse to give my rights to third party payments to the Department of Health and Human Services I will not be eligible for Medicaid.